ILLINOIS DEPARTMENT OF Healthcare and Family Services

Rod R. Blagojevich, Governor
Barry S. Maram, Director

201 South Grand Avenue East
Springfield, Illinois 62763-0002

Telephone: 1-877-782-5565
TTY: (800) 526-5812

INFORMATIONAL NOTICE

DATE: February 27, 2007

TO: Participating Hospitals – Chief Executive Officers, Chief Financial Officers, Patient Accounts Managers, and Utilization Review Departments

RE: Changes to Utilization Review

This notice provides an update on forthcoming utilization review changes.

Mandatory Concurrent Review
Mandatory concurrent review (certification of admission and continued stay review) will be implemented effective with admissions on and after March 1, 2007, for those diagnoses on Attachments A, B, and C. However, based on input from various stakeholders, HFS is allowing a 90-day transition period for hospitals to comply with mandatory concurrent review. During the transition period, hospitals will receive informational message I08– "Admit to Have Been Reviewed Concurrently" on the Remittance Advice.

All Illinois hospitals and out-of-state hospitals in counties contiguous to Illinois must participate in Concurrent Review for all diagnoses subject to review. Attachments referenced in this notice can be downloaded from the department's Web site at:
http://www.hfs.illinois.gov/proqio/

Effective with admissions on and after June 1, 2007, hospitals that do not follow the mandatory concurrent review process will receive rejections with the new error code A88 – No Certification on File. Claims that did not receive certification of the admission will not be payable.

Exceptions to Mandatory Concurrent Review Effective June 1, 2007
The department will allow limited exceptions to mandatory concurrent review in the following circumstances:

- A participant's eligibility was backdated to cover the hospitalization.
- Medicare Part A coverage exhausted while the patient was in the hospital, but the hospital was not aware that Part A exhausted.
- Discrepancies associated with the patient's Managed Care Organization (MCO) enrollment at the time of admission.
- The patient remains unresponsive or has a physical or mental impairment during the hospitalization that prevents the hospital from identifying coverage under one of the department's medical programs.
- Other – the hospital must provide narrative description.

Claims that relate to an exception must be submitted with a cover memo that identifies the exception. The hospital must send these claims to the hospital's assigned billing consultant at the department for manual review. After HFS reviews the exception, the claim will suspend for retrospective prepayment review.

Exceptions relating to Medicare Part A exhaust require Medicare verification of exhausted benefits.

Restriction on Volume of Retrospective Prepayment Reviews
Effective June 1, 2007, HSI will conduct quarterly analysis for HFS regarding the number of claims impacted by exceptions to mandatory concurrent review. Recognizing that it may be difficult for hospitals to achieve 100% mandatory concurrent review, HFS is allowing up to 10% of the reviews to suspend for retrospective prepayment review. HFS will monitor individual hospitals' performance to ensure this threshold is maintained. This does not change the current policy for psychiatric hospitalizations for children and adolescents under the Children's Mental Health Program.

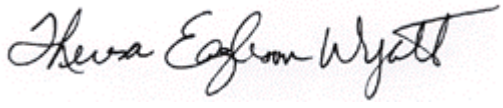
Off-Site Reviews
In an informational notice dated November 28, 2006, the department notified hospitals that effective March 1, 2007, HealthSystems of Illinois (HSI) will only conduct **off-site** reviews for all diagnosis codes and DRGs subject to review. Hospitals will be required to submit the medical record to HSI for review. Additionally, the hospital will be required to submit the medical record for inpatient stays selected for postpayment review. HSI will continue to provide the hospitals' Medicaid liaisons with the list of records that will be subject to review.

Additional Code Information

- Hospitals are informed that any 4th or 5th digit code extension of a three-digit root code, approved as the admitting diagnosis code at the time of the certification of admission, will be acceptable on the claim submitted to the department. As an example, if the code supplied by the hospital to HSI at the time of the certification of admission was 585.1, but the code on the actual claim submitted was 585.2, the claim will pass through the edit.

- Diagnosis code 038.9 was inadvertently omitted from Attachment C when Attachments A-D were last posted to the Web site in November 2006. This code was subject to review prior to the last update and continues to be subject to review. Attachment C has been corrected.

Any questions regarding the review process may be directed to HSI at the Toll-Free Helpline at 800-418-4045. Any questions regarding this notice may be directed to the Bureau of Healthcare Quality Improvement at 217-557-1031.



Theresa Eagleson Wyatt
Acting Administrator
Division of Medical Programs